Affordable Care Act
Toolkit | Large Employers

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This Toolkit is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice. The contents of this document may be affected by future regulations and sub-regulatory guidance.

Introduction

The Affordable Care Act (ACA) is the comprehensive health care reform law enacted in 2010. The ACA has many complex requirements for employers and their health plans. Although the ACA's reforms have been in effect for many years, it is still important for employers to periodically review their compliance with the ACA's requirements.

This Toolkit is your one-stop guide for ACA concerns. It is designed to help you address ACA issues, topic-by-topic, step-by-step.

Each section of the Toolkit focuses on a single subject and includes:

- A summary of the specific ACA requirement; and
- Action items to help you take the appropriate steps to ensure compliance.

This Toolkit is focused on large employers and will take you through the ACA considerations for these employers.

Who is a large employer?

The ACA doesn't have a consistent answer for that. An employer might be considered "large" for one rule, but not another. For this Toolkit, a large employer is one that has **50 or more employees**. Most of the sections in this guide apply to employers of this size. However, keep in mind that many of the ACA's reforms for health plan coverage apply to all employers, regardless of size.

Employer Shared Responsibility Rules

Applicable large employers (ALEs)—those with, on average, 50 or more full-time (and full-time equivalent) employees during the prior calendar year—that do not offer affordable, minimum value health coverage to their full-time employees (and their dependent children) will be subject to penalties if any full-time employee receives a subsidy for health coverage through an Exchange. These employer penalties are known as the "employer shared responsibility" or "pay or play" rules.

Determining ALE Status

The employer's size for purposes of the employer shared responsibility rules is based on the average employee count over the prior calendar year. Part-time employees are included in the calculation according to a formula, but do not have to be offered coverage. Special rules apply for counting certain types of employees, including seasonal, volunteer and foreign employees. Companies with common ownership may have to be combined to determine ALE status.

Penalty Amount

An ALE will be subject to an employer shared responsibility penalty only if one or more full-time employees obtain a subsidy through an Exchange. Employees who are offered affordable, minimum value health coverage are generally not eligible for these Exchange subsidies.

Depending on the circumstances, one of two penalties may apply under the pay or play rules—the 4980H(a) penalty or the 4980H(b) penalty.

4980H(a) Penalty

Under Internal Revenue Code (Code) Section 4980H(a), an ALE will be subject to a penalty if it does not offer coverage to "substantially all" (generally, at least 95%) of its full-time employees (and dependents) and any of its full-time employees receives an Exchange subsidy. The monthly penalty assessed on ALEs that do not offer coverage to substantially all full-time employees (and their dependents) is equal to the ALE's number of full-time employees (minus 30) multiplied by 1/12 of $2,000 (as adjusted), for any applicable month.

This penalty amount is adjusted for inflation each year. The adjusted penalty amount is **$2,750 for 2022**, **$2,880 for 2023** and **$2,970 for 2024**.

4980H(b) Penalty

Under Code Section 4980H(b), ALEs that offer coverage to substantially all full-time employees (and dependents) may still be subject to a penalty if at least one full-time employee obtains an Exchange subsidy because the ALE did not offer coverage to all full-time employees, or the ALE's coverage is unaffordable or does not provide minimum value. The monthly penalty assessed on an ALE for each full-time employee who receives a subsidy is 1/12 of $3,000 (as adjusted) for any applicable month. However, the total penalty for an ALE is limited to the 4980H(a) penalty amount.

This penalty amount is also adjusted for inflation each year. The adjusted penalty amount is **$4,120 for 2022**, **$4,320 for 2023** and **$4,460 for 2024**.

Action Items

Determine Employer Size

Count the number of employees according to the steps below to determine whether your organization is an ALE subject to the employer shared responsibility rules. Include all common law employees in the calculation, and count employees of all related companies according to the controlled group and affiliated service group rules in Code Section 414.

- Calculate the number of full-time employees (including seasonal employees) for each calendar month in the preceding calendar year. A full-time employee for a month is an employee who is employed, on average, at least 30 hours of service per week (or 130 hours per month).
- Calculate the number of full-time equivalent (FTE) employees (including seasonal employees) for each calendar month in the preceding calendar year by adding up the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not full-time employees for that month and dividing the total hours of service by 120.
- Add up the number of full-time and FTE employees (including fractions) calculated above for each month in the preceding calendar year.
- Add up the 12 monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.

Determine Whether Coverage Is Offered to Full-time Employees (and Dependents)

To predict whether your organization will be subject to an employer shared responsibility penalty, determine whether your organization offers coverage to substantially all full-time employees (and dependents). Coverage does not need to be provided during a permissible waiting period.

- All common law employees that work an average of at least 30 hours per week (or 130 hours per calendar month) must be considered full-time.
- An ALE must use a monthly measurement method to determine full-time employee status, unless it adopts the look-back measurement method for all employees or certain categories of employees, as permitted by the IRS.
- The monthly measurement method involves a month-to-month analysis of hours of service. Under this method, an employee's full-time status for a calendar month is determined based on hours of service for that month. This month-to-month measuring may cause practical difficulties for ALEs who have employees with varying hours or work schedules, as it could result in employees moving in and out of coverage on a monthly basis.
- If your organization has variable hour or seasonal employees, where it is uncertain if they will work the requisite number of hours, using the look-back measurement method may provide more predictability for determining full-time employee status.

- The look-back measurement method involves—a measurement period for counting hours of service; an optional administrative period that allows time for enrollment and disenrollment; and a stability period during which coverage is provided if the employee averages full-time hours during the prior measurement period. An ALE has discretion in deciding when these periods begin and how long they will last, subject to specified IRS parameters.

Determine Whether Coverage Is Affordable

An ALE's health coverage is considered affordable if the employee's required contribution to the plan does not exceed 9.5% (as adjusted) of the employee's household income for the taxable year. For plan years beginning in 2023, the affordability percentage is 9.12%. For plan years beginning in 2024, the affordability percentage is 8.39%.

Because an employer generally will not know an employee's household income, the IRS has provided **three optional affordability safe harbors** that ALEs may use to determine affordability based on information that is available to them. To predict whether your organization will be subject to a penalty for not providing affordable coverage, assess the affordability of your organization's health coverage under one of the IRS's affordability safe harbors.

- Under the Form W-2 safe harbor, determine if the employee portion of the lowest cost self-only premium does not exceed 9.5% (as adjusted) of the employee's W-2 wages.

- Under the rate of pay safe harbor, determine if coverage is affordable based on an employee's rate of pay. The employee's monthly contribution amount for the lowest cost self-only premium is affordable if it is equal to or lower than 9.5% (as adjusted) of the computed monthly wages.

- Under the federal poverty line (FPL) safe harbor, determine if coverage is affordable based on the FPL for a single individual in effect six months prior to the beginning of the plan year. Employer-provided coverage is affordable if the employee's contribution for the lowest cost self-only coverage does not exceed 9.5% (as adjusted) of the single FPL.

Determine Whether Coverage Provides Minimum Value

In general, an employer's health plan provides minimum value only if the plan's share of the total allowed cost of benefits provided to an employee is at least 60%, and the plan provides substantial coverage of inpatient hospitalization and physician services.

Review whether the plan provides minimum value by covering at least 60% of the cost of benefits, using one of the four available methods.

- Under the minimum value calculator approach, enter plan design data into the Minimum Value Calculator to determine minimum value.

- Under the safe harbor checklist approach, if the plan's terms are consistent with or more generous than any one of the safe harbor checklists, the plan will be treated as providing minimum value.

- If neither the calculator nor the checklists can be used because a plan has nonstandard features, seek an actuary's certification that the plan provides minimum value.
- Also, any plan in the small group market that meets any of the "metal levels" of coverage provides minimum value.

In addition, confirm that the plan provides substantial coverage for in-patient hospitalization and physician services.

Health Coverage Reporting

Reporting of Health Coverage (Sections 6055 and 6056)

These ACA reporting requirements apply to:

- **Employers with self-insured health plans (Section 6055)**—Every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage must file information returns with the IRS reporting information for each individual who is provided with this coverage during the calendar year. Related statements must also be provided to covered individuals.

- **ALEs (Section 6056)**—ALEs subject to the ACA's employer shared responsibility rules must file information returns with the IRS reporting the terms and conditions of the health coverage offered to full-time employees for the calendar year. Related statements must also be provided to full-time employees.

Penalties generally apply for failures to file correct information returns or provide correct individual statements by the deadlines.

Deadlines

Returns must be filed with the IRS annually, no later than **March 31** of the year following the calendar year to which the return relates, if filing electronically. The deadline for filing paper returns is earlier (Feb. 28). However, starting in 2024, employers that file at least 10 returns during the calendar year must file their ACA returns electronically.

Due to a permanent deadline extension, individual statements generally must be provided on or before **30 days from Jan. 31** of the year immediately following the calendar year to which the statements relate. This means that employers have until March 2 (or March 1 in a leap year) to furnish ACA statements. If the extended furnishing deadline falls on a weekend day or legal holiday, statements will be timely provided if they are furnished on the next business day.

In addition, The IRS has provided an alternative method for furnishing statements to individuals under Section 6055. This alternative method generally requires statements to be provided upon request only.

Forms

ALEs reporting under Section 6056 use Forms 1094-C and 1095-C. In general, employers reporting under Section 6055 use Forms 1094-B and 1095-B. However, ALEs that sponsor self-insured plans must report under both Section 6055 and Section 6056. These ALEs use a combined reporting method on Forms 1094-C and 1095-C to report the information required under both Section 6055 and Section 6056.

Action Items

- Determine whether your organization is a sponsor of a self-insured health plan or an ALE.

- Track and record the information that must be reported for the calendar year under Section 6055 and/or Section 6056, as applicable.

- Provide required information regarding plan coverage and participation to the IRS and to individuals by the applicable deadlines.

Form W-2 Reporting

Large employers are required to report the aggregate cost of employer-sponsored health plan coverage on their employees' Forms W-2. The purpose of the reporting requirement is to provide information to employees regarding how much their health coverage costs. The reporting does not mean that the cost of the coverage is taxable to employees.

In general, all large employers that provide health plan coverage must comply with the Form W-2 reporting requirement.

Employers that do not meet the definition of "large employer" for this section may be subject to this reporting in the future. The IRS has delayed the reporting requirement for these smaller employers by making it optional for these employers until further guidance is issued.

Large and Small Employers

For this requirement, an employer is considered a large employer if it was required to file **at least 250 Forms W-2 for the prior calendar year**. The IRS has indicated that the Code's corporate aggregation (common ownership) rules do not apply for purposes of determining whether an employer filed fewer than 250 Forms W-2 for the prior year. However, if an employer files fewer than 250 Forms W-2 only because it uses an agent to file them, the employer does not qualify for the small employer exemption.

Reporting Requirements

The coverage that must be reported is "applicable employer-sponsored coverage," which is group health plan coverage provided to an employee by the employer and which is excludable from the employee's gross income. The IRS has excluded certain types of coverage from the reporting requirement and has made reporting of other types optional.

The amount that must be reported is the aggregate cost of the coverage, including both the employer and employee portions of the cost. The cost must be determined on a calendar year basis. The IRS has identified a few different methods for calculating the cost, which are also used for calculating the cost of COBRA coverage.

Action Items

- Determine whether your organization is subject to the requirement by reviewing the number of W-2 Forms filed for the prior tax year.

- If your organization is subject to the reporting requirement, identify the types of coverage provided that must be reported.

- Calculate the total cost of coverage (employer plus employee portions) under each plan.

- Determine the coverage that was provided to each employee over the course of the applicable tax year.
- Include the value amount of that coverage during the W-2 preparation process.

Dependent Coverage to Age 26

Health plans that provide dependent coverage of children must make coverage available for **adult children up to age 26,** regardless of the child's student or marital status.

Coverage Requirement

Under this ACA rule, a child's eligibility for dependent coverage must be based solely on the child's age and his or her relationship to the employee. If the child is under age 26 and is the employee's child, he or she is eligible for dependent coverage. This means that a plan or issuer may not deny or restrict coverage for a child who is under age 26 based on whether the child is financially dependent on the employee, resides with the employee or with any other person, is a student, is employed or any combination of these factors.

The terms of the plan or coverage providing dependent coverage of children, including premiums charged, cannot vary based on age (except for children who are age 26 or older). This means that adult children must be offered all of the benefit packages available to other plan participants and cannot be required to pay more for coverage. For example, a plan may not impose an additional premium surcharge for children who are older than age 18. This type of surcharge would violate the uniformity requirement because the plan varies the terms for dependent coverage of children based on age.

Tax Rules

The ACA also revised the Code to provide that the extended dependent coverage is tax-free to the employee. Under the Code, tax-free coverage is available for a child who has not attained age 27 as of the end of the taxable year. This means that coverage for an adult child is tax-free through the end of year in which the child attains age 26.

Action Items

- Confirm that the plan provides dependent coverage up to age 26 on a tax-free basis.
- Confirm that the plan's coverage (including premiums) does not vary based on a child's age (except for children who are age 26 or older).

Excessive Waiting Periods

Health plans may not impose a waiting period that exceeds **90 days**. When applying the ACA's 90-day waiting period limit, all calendar days must be counted, beginning on the enrollment date, including weekends and holidays.

Waiting Period

A waiting period is the period of time that must pass before coverage for an employee or dependent who is otherwise eligible to enroll becomes effective. An employee or dependent is otherwise eligible for coverage when he or she has met the plan's substantive eligibility conditions.

Eligibility conditions that are based solely on the lapse of time are permissible for no more than 90 days. However, other conditions for eligibility are permissible, as long as they are not designed to avoid compliance with the 90-day waiting period limit. Permissible eligibility conditions include:

- Being in an eligible job classification;
- Achieving job-related licensure requirements specified in the plan's terms; or
- Satisfying a reasonable and bona fide employment-based orientation period that does not last longer than one month.

Variable Hour Employees
A special rule applies if a health plan conditions eligibility on an employee regularly working a specified number of hours per pay period (or working full time), and it cannot be determined that a newly hired employee is reasonably expected to regularly work that number of hours per period (or work full time).

In this type of situation, the plan may take a reasonable period of time to determine whether the employee meets the plan's eligibility condition. This may include a measurement period consistent with the employer shared responsibility rules (even if the employer is not an applicable large employer). The time period for determining whether a variable hour employee meets the plan's eligibility condition will comply with the 90-day waiting period limit if coverage is effective no later than 13 months from the employee's start date, except where a waiting period that exceeds 90 days is imposed after the measurement period. If an employee's start date is not the first of the month, the time period can also include the time remaining until the first day of the next calendar month.

Action Items
- Review whether your health plan imposes a waiting period for participation.
- If a waiting period is imposed, ensure that it does not exceed 90 days.
- If it is unclear whether a new employee will work the required number of hours, set a measurement period to determine whether the hours requirement will be met in the future.

Lifetime and Annual Benefit Limits

Health plans may not place lifetime and annual dollar limits on essential health benefits (EHB), regardless of whether the benefits are provided by an in-network or out-of-network provider. The ACA's prohibition on lifetime and annual dollar limits applies only to a health plan's coverage of EHB. Health plans may impose annual or lifetime limits on specific covered benefits that are not EHB.

Also, self-insured health plans, large group market health plans and grandfathered plans can exclude all benefits for a condition without being considered an annual limit, as long as no benefits are provided for the condition.

EHB
Under the ACA, EHB must reflect the scope of benefits covered by a typical employer and cover at least 10 general categories of items and services, such as emergency services, hospitalization, maternity care, mental health and substance use disorder benefits and prescription drugs.

Non-grandfathered insured health plans in the small group market must cover the EHB package. Each state has a specific benchmark plan that defines EHB for small group market plans.

The requirement to cover EHB does not apply to grandfathered health plans, self-insured group health plans and health insurance plans in the large group market. However, the ACA prohibits these plans from imposing annual and lifetime dollar limits on covered benefits that fall within the definition of EHB. Health plans that are not required to provide EHB may select from any of the approved benchmark plans to determine which benefits cannot be subject to annual and lifetime dollar limits.

Action Items

- Ensure that no lifetime or annual limits are imposed on EHBs.
- For a non-grandfathered plan in the small group market, use the state's benchmark plan to determine which benefits are EHBs. For a self-insured health plan, large group market health plan or grandfathered plan, use the selected benchmark plan to determine which benefits are EHBs.

Limit on Cost Sharing

Non-grandfathered health plans are subject to annual limits on total enrollee cost-sharing for EHB, known as an **out-of-pocket maximum**. Because the cost-sharing limit applies only to EHB, plans are not required to apply the annual out-of-pocket maximum to benefits that are not EHB.

Cost-sharing Limit

Cost sharing includes any expenditure required by or on behalf of an enrollee with respect to EHB, such as deductibles, co-payments, co-insurance and similar charges. It excludes premiums and spending for non-covered services. Also, plans using provider networks are not required to count an enrollee's cost sharing for out-of-network benefits toward the cost-sharing limit.

The cost-sharing limit is adjusted for inflation each year, as follows:

- For plan years beginning in 2022, the cost-sharing limit is $8,700 for self-only coverage and $17,400 for family coverage.
- For plan years beginning in 2023, the cost-sharing limit is $9,100 for self-only coverage and $18,200 for family coverage.
- For plan years beginning in 2024, the cost-sharing limit is $9,450 for self-only coverage and $18,900 for family coverage.

Special Rule for Family Coverage

The self-only cost-sharing limit applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage. This requirement effectively embeds an individual out-of-pocket maximum in family coverage when the out-of-pocket maximum for family coverage exceeds the ACA's cost-sharing limit for self-only coverage.

Action Items

- Confirm that a non-grandfathered health plan's out-of-pocket maximum complies with the ACA's cost-sharing limit.

- Ensure that each individual's out-of-pocket maximum does not exceed the ACA's cost-sharing limit for self-only coverage, even if the individual has family coverage.

Preventive Care Services

Non-grandfathered health plans must cover certain preventive health services without imposing cost-sharing requirements (that is, deductibles, copayments or coinsurance) for the services when they are provided by in-network providers.

Coverage Guidelines

The covered preventive care services include:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA.

Health plans are required to adjust their first-dollar coverage of preventive care services based on the latest preventive care recommendations. More information on the recommended preventive care services is available from HealthCare.gov.

UPDATE: On March 30, 2023, a federal district court in Texas issued a ruling that affects portions of the ACA's coverage requirement for preventive care services. The court ruled that preventive care coverage requirements based on an A or B rating by the USPSTF on or after March 23, 2010, violate the U.S. Constitution. The court also ruled that the requirement to cover HIV preexposure prophylaxis (PrEP) drugs violates the Religious Freedom Restoration Act. Accordingly, the court granted an injunction against the enforcement of those requirements and vacated all related agency actions. The impact of the ruling on specific employer plans remains unclear at this point. The ruling has been appealed to a higher court and may be stayed while litigation is ongoing.

Action Item

- Confirm that a non-grandfathered health plan covers the recommended preventive services without imposing any cost-sharing (such as deductibles, copayments or coinsurance) for the services.

Pre-existing Condition Exclusions

Health plans may not impose pre-existing condition exclusions on any covered individual. A pre-existing condition exclusion is a limitation or exclusion of benefits related to a condition based on the fact that the condition was present before the individual's date of enrollment in the employer's plan.

Action Item

- Ensure that no pre-existing condition exclusion is imposed on any individual.

Patient Protections

The ACA imposes three requirements on health plans that are referred to as "patient protections." These patient protections relate to the choice of a health care professional and requirements relating to benefits for emergency services.

- Health plans that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children).

- Health plans that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

- Health plans that provide benefits for emergency services must provide those benefits without requiring prior authorization, and without regard to whether the provider is an in-network provider. Also, the plan or issuer may not impose requirements or limitations on out-of-network emergency services that are more restrictive than those applicable to in-network emergency services. Cost sharing requirements, such as copayments or coinsurance rates imposed for out-of-network emergency services, cannot exceed the cost-sharing requirements for in-network emergency services.

"No Surprises Act" Changes

The "No Surprises Act" (NSA), which was enacted as part of the Consolidated Appropriations Act, 2021, reorganized and expanded the ACA's patient protections, effective for plan years beginning on or after Jan. 1, 2022. The NSA expanded the ACA's patient protections by:

- Applying the patient protections to grandfathered health plans, which were exempted from the ACA's original patient protections.

- Expanding the definition of "emergency services" to include care received in an independent freestanding emergency department, as well as care received in an emergency department of a hospital; and

- Providing federal protections against surprise medical billing by limiting out-of-network cost sharing and prohibiting "balance billing" in many of the circumstances in which surprise medical bills arise most frequently.

Action Items

- If the plan requires participants to choose a primary care provider, allow participants to choose any available participating primary care provider or pediatrician.
- Permit participants to obtain OB/GYN care without a pre-authorization or referral.
- Confirm there are no pre-authorization requirements for emergency services and that the cost sharing for out-of-network emergency services is not more than the cost sharing for in-network emergency services.

Recissions of Coverage

Health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A “rescission” is a cancellation or discontinuance of coverage that has a retroactive effect. A termination of coverage that has a retroactive effect is permissible if it is due to the participant’s failure to pay required premiums or contributions for the coverage.

Action Items

- Before terminating coverage for a participant, review whether the termination will have a retroactive effect.
- If yes, confirm that the retroactive termination is due to fraud, intentional misrepresentation or non-payment for coverage. Rescissions are not permitted based on an inadvertent misstatement or to correct a plan error (such as mistakenly covering an ineligible employee).

Coverage for Clinical Trial Participants

Non-grandfathered health plans may not:

- Terminate coverage because an individual chooses to participate in a clinical trial for cancer or other life-threatening diseases; or
- Deny coverage for routine care that they would otherwise provide just because an individual is enrolled in such a clinical trial.

Action Item

- Ensure that plan terms and operations do not discriminate against participants who participate in clinical trials.

Contribution Limit for Health FSAs

An employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) must be limited to $2,500 (as adjusted). The health FSA limit is adjusted annually, as follows:

- $2,850 for taxable years beginning in 2022.
- $3,050 for taxable years beginning in 2023.

Health FSA plan sponsors are free to impose an annual limit that is lower than the ACA limit for employees' health FSA contributions. Also, the limit does not apply to employer contributions to the health FSA and it does not impact contributions under other employer-provided coverage. For example, employee salary reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the health FSA limit.

Action Item

- Confirm that your health FSA does not allow employees to make pre-tax contributions in excess of the ACA limit in effect for the year.

Health FSA Carryovers

The IRS relaxed the "use-or-lose" rule for health FSAs in connection with the ACA's reforms. Under the relaxed rule, employers may allow participants to carry over up to $500 (as adjusted annually) in unused funds into the next year.

- For plan years beginning in 2022, the carry-over limit is $570.
- For plan years beginning in 2023, the carry-over limit is $610.

This carryover rule does not affect the limit on salary reduction contributions. This means the plan may permit the individual to elect up to $2,500 (as adjusted) in salary reductions in addition to the $500 (as adjusted) that may be carried over. Carryovers are not allowed if a health FSA incorporates an extended deadline—or grace period—after the end of the plan year to use health FSA funds.

Action Item

- Decide whether your health FSA should allow carryovers of unused funds up to $500 (as adjusted).
- If your health FSA allows carryovers, confirm that the carryover amount does not exceed the limit in effect for the year.

Design Requirements for Health FSAs

As group health plans, health FSAs are subject to certain ACA reforms. Most health FSAs must qualify as "excepted benefits" to satisfy these reforms. Health FSAs qualify as excepted benefits if they satisfy availability and maximum benefit requirements as follows:

- **Availability**—Other non-excepted health plan coverage (for example, coverage under a group health plan) must be made available to health FSA participants.

- **Maximum Annual Benefit**—The maximum annual benefit payable to the employee under the health FSA cannot exceed two times the employee's salary reduction under the health FSA for that year (or, if greater, the amount of the employee's salary reduction election plus $500).

Retiree-only health FSAs and health FSAs that only provide limited-scope dental or vision benefits qualify as excepted benefits under the ACA based on their design, and do not have to satisfy the availability and maximum benefit requirements.

Action Item

- Review your health FSA plan design to confirm that it qualifies as an excepted benefit (or falls under an exception).

Design Requirements for HRAs

As group health plans, HRAs are subject to certain ACA reforms. Most HRAs must be integrated with other group health coverage to be permissible. The IRS and DOL have provided two ways for an HRA to be considered integrated with another group health plan. Stand-alone HRAs are prohibited unless they qualify for an exception.

Integration Methods

There are two ways for an HRA to be considered “integrated” with another group health plan. One method imposes a minimum value requirement on the non-HRA group health plan coverage. The other method limits the types of expenses that can be reimbursed under the HRA.

Neither integration method requires the HRA and the coverage with which it is integrated to share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable. Under both integration methods, the following four requirements must be met:

1. The employer sponsoring the HRA must sponsor a group health plan (other than the HRA) that provides more than just excepted benefits.

2. Employees (and their spouses and dependent children) who are covered under the HRA must be enrolled in another group health plan that provides more than just excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage).

3. The HRA must be available only to employees (and their spouses and dependent children) who are enrolled in the non-HRA group coverage, regardless of whether the employer sponsors the plan.

4. Employees (and former employees) must be offered the opportunity to permanently opt out and waive future reimbursements from the HRA at least annually. On termination of employment, the remaining amounts in the HRA must be forfeited or the employee must be permitted to permanently opt out of and waive future reimbursements.

If the non-HRA group health plan coverage described in the first three requirements above meets the ACA’s minimum value requirement, the HRA may

reimburse any type of permitted medical care expense. However, if the minimum value standard is not met by the non-HRA group health plan coverage, the HRA can only reimburse copayments, coinsurance, deductibles and premiums under integrated non-HRA group coverage, as well as medical care that does not constitute essential health benefits.

Reimbursing Individual Premiums
In general, employers cannot reimburse employees for individual health insurance premiums (through an HRA or any other type of employer payment plan) without violating the ACA. However, this restriction does not apply to HRAs that are exempt from the ACA's market reforms, such as retiree-only HRAs and qualified small employer HRAs (QSEHRAs).

Also, beginning in 2020, employers may adopt individual coverage HRAs (ICHRAs) to reimburse employees' individual health insurance premiums. However, note that ICHRAs are subject to some strict design requirements. Also, employees who are covered under ICHRAs are not eligible for subsidies for health coverage purchased through an Exchange.

Action Items
- Review your HRA plan design to confirm that it satisfies the requirements for being integrated with another group health plan.
- To reimburse individual health insurance premiums, confirm that you are using an acceptable HRA design, such as a QSEHRA or ICHRA.

Cafeteria Plans

The IRS allows cafeteria plans to permit mid-year election changes in certain situations related to the availability of Exchange coverage. A cafeteria plan may allow an employee to prospectively revoke his or her election for coverage under the employer's group health plan during a period of coverage (as long as the plan provides minimum essential coverage and is not a health FSA) in the following situations:

- The employee's hours of service are reduced so that the employee is expected to average less than 30 hours per week, but the reduction does not affect eligibility for coverage under the employer's group health plan; or
- The employee (or one or more family members, effective Jan. 1, 2023) would like to cease coverage under the employer's group health plan and purchase coverage through an Exchange during a special enrollment period or the Exchange's annual open enrollment period.

Certain conditions must be met for the change to be permitted. Also, an election to revoke coverage on a retroactive basis is not allowed.

Action Item
- If you have a cafeteria plan, consider amending the plan for the mid-year election change rules. Cafeteria plans can be amended retroactively to implement these rules, if the retroactive amendment is made on or before the last day of the plan year and is communicated to participants.

Patient-Centered Outcomes Research Institute (PCORI) Fees

Employers with self-insured health plans and health insurance issuers must pay fees to finance comparative effectiveness research. These research fees are commonly called Patient-Centered Outcomes Research Institute fees (PCORI fees). The fees were scheduled to apply for plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. However, PCORI fees were extended and **now apply through the 2029 fiscal year.**

PCORI fees are **due by July 31** of the calendar year following the plan year to which the fee applies. The fee amount is adjusted each year as follows:

- For plan years ending on or after Oct. 1, 2022, and before Oct. 1, 2023, the fee amount is $3.00.
- For plan years ending on or after Oct. 1, 2023, and before Oct. 1, 2024, the PCORI fee amount is $3.22.

Note that an HRA is not subject to a separate PCORI fee if it is integrated with another self-insured plan providing major medical coverage, as long as the HRA and the health plan are established and maintained by the same plan sponsor and have the same plan year. If an HRA is integrated with an insured group health plan, the plan sponsor of the HRA and the issuer of the insured plan will both be subject to the research fees, even though the HRA and insured group health plan are maintained by the same plan sponsor.

Action Items

- If you have a self-insured health plan, make sure to pay PCORI fees by the July 1 deadline each year.
- If a plan is insured, the carrier is responsible for paying the fee, although the carrier may shift the fee to your organization through a premium increase.
- If there is an HRA, determine whether it qualifies for the exception for multiple self-funded plans, or whether it is subject to the research fee.

Notices and Disclosures

Summary of Benefits and Coverage

Health plans and health insurance issuers must provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries to help them understand their coverage and make coverage decisions.

Providing the SBC

Health plans or issuers must provide an SBC to participants and beneficiaries with respect to each benefit package for which the participant or beneficiary is eligible. The SBC must be provided:

- As part of any written application materials that are distributed by the plan or issuer for enrollment;
- If the plan or issuer does not distribute written application materials, no later than the first date that the participant is eligible to enroll in coverage;
- By the first day of coverage, if there was any change to information required to be in the SBC that was provided upon application and before the first day of coverage;
- To special enrollees, no later than the deadline for providing the summary plan description (SPD) (that is, within 90 days of enrollment);
- Upon renewal, if participants and beneficiaries must renew to maintain coverage; and
- Upon request.

For self-insured plans, the employer is usually responsible for providing the SBC. For insured plans, both the plan and the issuer are obligated to provide the SBC; however, this obligation is satisfied for both parties if either one provides the SBC.

SBC Template

The SBC must follow strict formatting requirements. Federal regulators have provided an SBC template and related materials (including instructions and a uniform glossary of coverage terms) for plans and issuers to use.

Action Items

- Confirm that an SBC has been developed for each health plan that the company offers.
- Confirm that the SBC is being provided to participants and beneficiaries in accordance with the required deadlines.
- If you have an insured health plan, review whether the issuer has assumed responsibility for preparing and providing the SBC.

60-Day Advance Notice of Plan Changes

A health plan or health insurance issuer must provide **60 days' advance notice of any material modifications to the plan** that are not related to renewals of coverage. Specifically, the 60-day advance notice must be provided when a

material modification is made that would affect the content of the SBC and the change is not already included in the most recently provided SBC.

This notice can be provided in an updated SBC or a separate summary of material modifications (SMM).

Material Modification
A "material modification" is any change to a plan's coverage that would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage. A material modification may include an enhancement in covered benefits or services or other more generous plan or policy terms, a material reduction in covered services or benefits or more strict requirements for receiving benefits.

Action Items
- Analyze proposed plan changes that are not related to renewal to determine if they are material modifications to the plan.
- If a mid-year change is a material modification, provide notice of the change at least 60 days before its effective date by providing a new SBC or an SMM.
- For insured plans, determine whether the issuer will provide this notice.

Notice of Patient Protections

Health plans and health insurance issuers that require designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Health plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for obstetrical/gynecological care.

Plan administrators or issuers of these plans must provide a Notice of Patient Protections whenever the summary plan description (SPD) or similar description of benefits is provided to a participant. This notice is often included within a plan's SPD. Model language is available from the Department of Labor (DOL).

Action Item
- Incorporate the Notice of Patient Protections into the SPD or benefits description.

Notice of Coverage Options (Exchange Notice)

Employers must provide all new hires with a written notice about coverage options available through the Exchange. In general, the Exchange Notice must:

- Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange;
- Explain how employees may be eligible for a subsidy if the employer's health plan does not meet certain requirements; and
- Inform employees that if they purchase coverage through the Exchange, they may lose any employer contribution toward the cost of employer-provided

coverage, and that all or a portion of this employer contribution may be excludable for federal income tax purposes.

There is no fine or penalty under the ACA for failing to provide an Exchange Notice.

Model Exchange Notices
The DOL has provided the following model Exchange Notices for employers to use, both of which require some customization:

- Model Notice to Employees of Coverage Options for employers who do not offer a health plan; and
- Model Notice to Employees of Coverage Options for employers who offer a health plan to some or all employees.

Action Items
- Customize the appropriate model Exchange notice.
- Prepare to provide a customized notice to all new employees when hired.

Notice of Rescission

Group health plans and health insurance issuers may not rescind coverage for covered individuals, except in the case of fraud or intentional misrepresentation of a material fact. A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect. A termination of coverage that has a retroactive effect is permissible if it is due to the participant's failure to pay required premiums or contributions for the coverage.

This prohibition applies to grandfathered and non-grandfathered health plans, whether coverage is insured or self-funded. If a rescission is permitted, the plan administrator or issuer must provide a notice of rescission to affected participants **at least 30 days before the rescission occurs**.

Action Item
- Before terminating coverage retroactively, provide 30 days' advance notice to the affected participant.

Statement of Grandfathered Status

Grandfathered plans are those that existed when the ACA was enacted in March 2010 and have not made certain changes to coverage or costs since then. To retain grandfathered status, these plans must provide a statement of grandfathered status to participants. Model language is available from the DOL.

Health plans lose grandfathered status if they make certain significant changes that reduce benefits or increase costs to consumers.

Action Items
- If you have a grandfathered plan, include a statement about the plan's grandfathered status in materials describing coverage under the plan, such as SPDs and open enrollment materials.

- If the plan loses grandfathered status, a statement does not have to be provided to plan participants. However, you should confirm that the plan includes all of the additional patient rights and benefits required by the ACA. This includes, for example, coverage of preventive care without cost-sharing requirements.